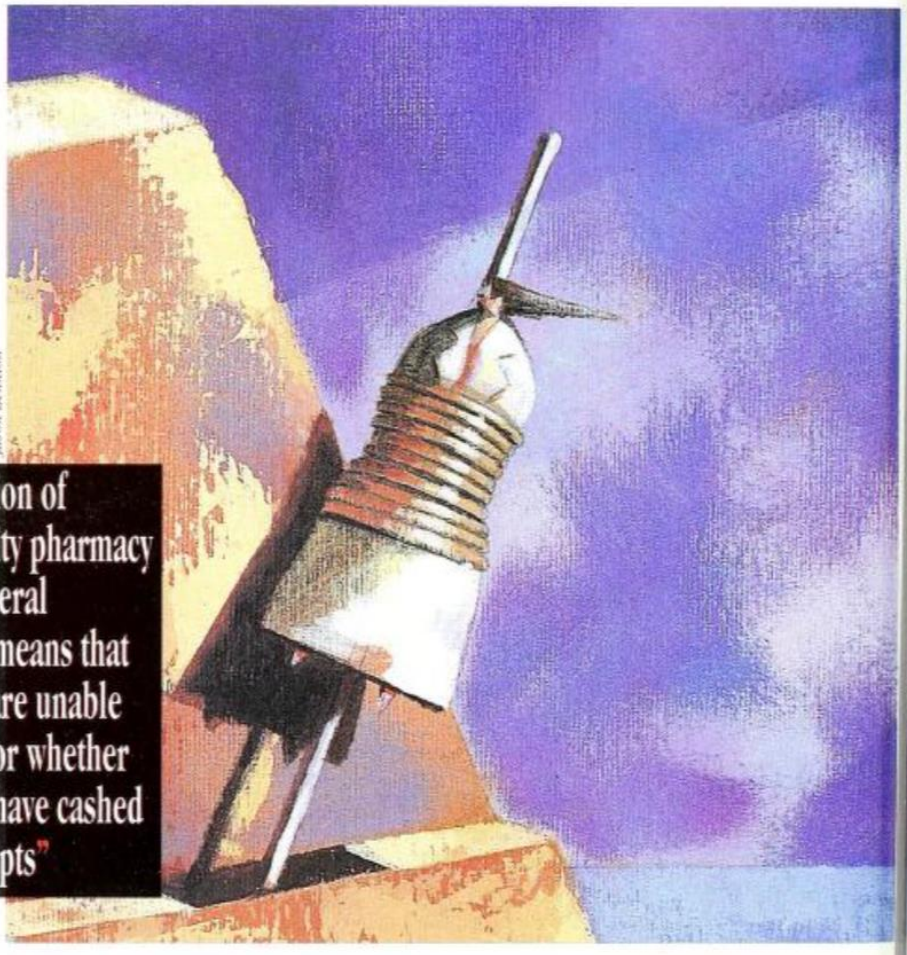
In the first of two articles proposing a radical change to the way pharmacists might be remunerated, health economist Dr Darrin Baines sets out the reasons for why pharmacy contractors are where they are now

Constrained by our past?

The time for radical change in community pharmacy is long overdue. The system is outdated and has failed to remove the constraints of its past. Its problems cannot be resolved through closer working with GPs, or by a greater emphasis on meeting consumer needs. More fundamental changes are required. The whole system needs to be dismantled and rebuilt in a completely different way. The result, however, will be a form of community pharmacy, but not as we know it.



Jason Brunton

Community origins

Community pharmacy in the UK has its origins in the mid-1700s, when chemists and druggists began to appear and to compete with their professional rivals, the apothecaries. Competition between the two groups encouraged each to seek a comparative advantage over the other. As a result, apothecaries increased their emphasis on medical practice and eventually became GPs.

> "Separation of community pharmacy from general practice means that doctors are unable to monitor whether patients have cashed their scripts"

Chemists and druggists fought for market share by developing the retail side of their activities and by locating themselves within easy to access local shops. Inadequacies in the public transport system meant that practitioners and pharmacists who did not locate near their patients were often forced out of business.

The separation of general practice from community pharmacy led to a professional split between those trained to provide general medical services and those specifically trained to oversee the dispensing of drugs. The National Insurance Scheme, and later the NHS, institutionalised this split by introducing separate organisational and financial arrangements for these activities.

Under the National Insurance Scheme, practitioners and pharmacists had to register with separate lists before they could provide patient services. Practitioners were also remunerated differently from pharmacists, with the former being paid for each insured patient registered with them and the latter being paid for each drug they dispensed. As a result, the system attached patients to practitioners, but gave pharmacists little control over anything other than the dispensing of drugs.

The NHS and you

The introduction of the NHS effectively ended private practice for GPs. Pharmacists, on the other hand, were part funded by their NHS dispensing fees and supplemented their incomes through their private, retail activities. As the NHS was introduced to provide access to healthcare services for the whole population, one of the first tasks faced by the system was how to encourage practitioners and pharmacists to work in areas that had not previously been financially viable. Generous incentives were offered to doctors to locate in new areas, while pharmacists were expected to part finance their moves through their own retail activities.

Although pharmacists faced differing economic conditions, their political leaders negotiated one national contract and terms of service for all community pharmacies. The national negotiators for family doctor

Continued on P28

→Continued from P28

also did the same. As a result of these arrangements, the NHS activities that pharmacists and practitioners could perform were clearly defined and were the same for all members of each profession. Individuals who wished to expand their activities, or to sign contracts that reflected their personal circumstances or local needs, were unable to do so.

The 1946 NHS Act instructed the administrative bodies for primary care, Executive Councils, to make the arrangements necessary for 'any person receiving general medical services to obtain proper and sufficient drugs and medicines and prescribed appliances, if ordered by the medical practitioner rendering those services'.

The financial and professional consequences of the Act for community pharmacists soon became clear. In the newly established NHS, they would have to stock any product that a practitioner was likely to prescribe and had no influence on the range or cost of medicines used. The introduction of the list system and capitation payments for GPs further disempowered community pharmacists.

While practitioners were instructed to establish a list of all individuals who wished to use their services, no formal links were established between community pharmacists and their patients. Practitioners were paid regardless of whether they treated the patients on their lists or not, while payments for pharmacists were linked to the activity of dispensing drugs.

Faults in the design

Many of the problems currently faced by community pharmacists are a direct result of the way in which the NHS was initially designed. As the box below shows, the new system embodied a number of design faults, which constrained the way in which community pharmacy subsequently developed. For example, the NHS has given pharmacists few incentives or opportunities to work in general practice. They have been unable to establish their own patient groups, and must derive their incomes by appealing to individual patients as the consumers of medicines.

Moreover, pharmacists have had no control over the range or cost of medicines that patients are prescribed and cannot negotiate contracts that reflect their personal abilities or circumstances.

Most importantly, the NHS has encouraged community pharmacy to develop in the same way as the system of small, independent chemists and druggists that first came into existence during the mid-1700s. As a result, community pharmacy in the NHS is still primarily centred around shop-based retailers located in areas easily accessible to patients.

The inadequacies in the design of community pharmacy outlined below cause a range of problems and fail to solve others created elsewhere. For example, the separation of community pharmacy from general practice means that doctors are unable to monitor whether their patients have cashed their scripts. Pharmacists must negotiate special access and funding before they can systematically advise local practitioners on their prescribing patterns and drug choice.

More importantly, the arrangements have forced community pharmacists to take a consumer-based approach to pharmaceutical care. As a result, they mainly provide a demand-led service, which is not structured to take account of the needs of local patient populations as a whole.

A future for pharmacy?

The second in this series of articles examines the ways in which the problems currently faced by community pharmacy may be addressed. To be successful, the solutions to these problems will have to be radical and revolutionise the way in which community pharmacy is currently structured and funded. As a result, there will still be community pharmacy, but not in the form that we currently know.

Dr Darrin Baines is a senior lecturer in health economics at the Health Services Management Centre, University of Birmingham, with an interest in primary care and prescribing. The concluding article will appear next week

Faults in the design of community pharmacy and their consequences

Design fault	Problems caused by fault
Split of general practice and community pharmacy	Artificial separation of practitioners from pharmacists, institutionalising the differences and rivalry between the two groups
Separation of prescribing and dispensing systems	Practitioners free to prescribe any drug they wished. Pharmacists unable to control drug costs or range of products used
Separate, national contracts for the two groups	Practitioners and pharmacists given different national contracts although they often served the same patient groups. Members of each profession all subject to the same contract, regardless of their abilities or circumstances
Lists for practitioners but not pharmacists	Individual practitioners able to establish their own patient groups, while pharmacists had no formal means of doing so
Different fee systems for practitioners and pharmacists	Did not encourage practitioners to work with pharmacists. Tied pharmacists to the dispensing act for their incomes, with the result that were not paid if they did not dispense
Access seen in terms of location	Encouraged general practice and community pharmacy to develop around a system of premises located in easy reach of local populations

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